MEDI-CAL UPDATE

Outpatient Services
Bulletin 342

Billing and Policy
Clinics and Hospitals Bulletin 342 **April 2003**

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Misuse of Benefits Identification Card: New BICs Issued

Effective March 2003, the Department of Health Services (DHS) Medical Review Branch is increasing the number of replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. Approximately 10,000 recipients per month will be issued BICs with new ID numbers and issue dates. This process may be further escalated as other misuses of BICs are discovered.

When any provider attempts to verify eligibility for the recipients who receive new cards by using the Social Security Number (SSN) or previous BIC number, the Automated Eligibility Verification System (AEVS) will return the eligibility message, "For claims payment, current BIC ID number and date of issue required." All providers must have and use the BIC ID number and issue date from the new card when verifying recipient eligibility. Providers, with the exception of the excluded provider types listed below, must have and use the BIC ID number and issue date from the new card when submitting claims for reimbursement. The SSN will not be acceptable in the recipient number field on claims. If the BIC ID number and issue date of the new card are not on the claim for recipients whose card returns the message, "For claims payment, current BIC ID number and date of issue required," the claim will be denied.

Note: The following excluded provider types (Alternative Birthing Centers, Community Hospital Inpatient, Community Hospital Outpatient, County Hospital Inpatient, County Hospital Outpatient, Genetic Disease Testing, Long Term Care Facility and Mental Health Inpatient) may bill with either the recipient's SSN or the BIC ID number. For all other provider types, the ID number and issue date of the card must be placed on all claims.

When referring recipients to other providers, such as laboratories, please indicate the BIC ID number and date of issue on the referral. If a provider, such as a laboratory, receives a referral without a recipient's BIC ID number and issue date, the laboratory must contact the referring provider for this information. For assistance with obtaining eligibility information, please call the AEVS Help Desk at 1-800-456-2387. For assistance with the POS device or the Medi-Cal Web site, call the POS/Internet Help Desk at 1-800-427-1295. If illegal use of a BIC is suspected, or if you have any questions about this policy, call the Provider Support Center (PSC) at 1-800-541-5555.

Sodium Hyaluronate Supartz: New Benefit

Effective for dates of service on or after May 1, 2003, Medi-Cal will reimburse up to a total of five injections per knee (one injection per week) of Sodium Hyaluronate Supartz 25 mg (HCPCS code X7486) to any provider for the same recipient. Prior authorization is required. If the series of treatment is repeated on either knee, or if the treatment is performed bilaterally, providers must document this in the *Remarks* area of the claim. The injections are reimbursable for patients who have:

- Painful osteoarthritis of one or both knees
- Significant knee pain, decreased mobility or significant effusion of the knee
- Knee pain that is not relieved from the use of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

This information is reflected on manual replacement pages inject 36 (Part 2) and inject list 17 (Part 2).

2002 CPT-4 Updates: Obstetrical Anesthesia

Medi-Cal reimbursement policies for the 2002 CPT-4 obstetrical anesthesia codes have been updated. The policy changes are highlighted below.

Obstetrical General and Regional Anesthesia

Effective for dates of service on or after December 2, 2002, CPT-4 codes 01960 – 01964, 01968 and 01969 may be billed for general, regional, or both general and regional anesthesia. Providers billing with any of these codes must include a statement in the *Remarks* area of the claim documenting whether the anesthesia was general, regional or both. Claims without such documentation will be denied. Claims billed for general anesthesia with codes 01960 – 01964, 01968 and 01969 must document "start-stop" times in the *Remarks* area. Providers billing these codes for regional or both general and regional anesthesia must document "time in attendance" (in addition to the "start-stop" times, if general anesthesia was also administered) in the *Remarks* area. *Refer to manual replacement page anest 3 (Part 2).*

Reimbursement Restriction for CPT-4 Code 01964

Effective for dates of service on or after May 1, 2003, reimbursement for CPT-4 code 01964 (anesthesia for abortion procedures) will be limited to once in 60 days (unless a subsequent abortion is medically necessary), to conform with current policies related to elective abortion procedures. *Refer to manual replacement pages abort 6 (Part 2) and presum 17 (Part 2).*

Ultrasound During Pregnancy: Billing and Restriction Update

Effective for dates of service on or after May 1, 2003, CPT-4 code 76805 (ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete [complete fetal and maternal evaluation]), 76815 (…limited [fetal size, heart beat, placental location, fetal position, or emergency in the delivery room]) or 76816 (…follow-up or repeat) may not be reimbursed when billed in conjunction with ICD-9-CM diagnosis codes V28.3 – V28.9 (antenatal screening), which have been deleted.

Note: The descriptions for codes V28.0 – V28.2 have been renamed "Guide for amniocentesis."

These changes do not apply to abortion policy. Diagnosis codes for ultrasounds performed in association with abortion have not changed. *This information is reflected on manual replacement pages preg early 4 thru 6 (Part 2) and presum 17 (Part 2).*

Synagis: Benefit Reminder

Synagis 100 mg and Synagis 50 mg injections are reimbursable once in a 25-day period and require a *Treatment Authorization Request* (TAR). If medically necessary, providers may request the amount of Synagis needed to cover a recipient's entire treatment period on one TAR. *This information is reflected on manual replacement page inject 10 (Part 2).*

Disproportionate Share Hospitals and Small and Rural Hospitals: Rate Adjustment

Effective for dates of service on or after January 1, 2003, in accordance with the *Welfare and Institutions Code,* Section 14105.97, the reimbursement rates for outpatient services provided by disproportionate share hospitals have been adjusted. In addition, reimbursement rates for outpatient services provided by small and rural hospitals have been adjusted in accordance with the *Health and Safety Code,* Section 124870. Such adjustments may result in an increase, a decrease or no change in the current outpatient rates for each participating hospital. These adjustments do not apply to hospitals under Section 1115 Medicaid Demonstration Project for Los Angeles County or provider-based Federally Qualified Health Centers.

Family PACT
Planning • Access • Care • Treatment

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When the Medi-Cal provider is not an individual, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Please see **Family PACT**, *page 4*

Family PACT *(continued)*

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations

The following dates and locations are scheduled for Spring 2003:

April 15, 2003

Fresno
Radisson Hotel
2233 Ventura Street
Fresno, CA 93721
For directions, call
(559) 268-1000

May 8, 2003

Santa Barbara
Radisson Hotel
1111 East Cabrillo Boulevard
Santa Barbara, CA 93103
For directions, call
(805) 963-0744

June 3, 2003

Chico
Holiday Inn
685 Manzanita Court
Chico, CA 95926
For directions, call
(530) 345-2491

June 19, 2003

Ontario
DoubleTree Hotel
Ontario Airport
222 North Vineyard Avenue
Ontario, CA 91764
For directions, call
(909) 937-0900

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials.

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

Completing the Provider Orientation and Update Session

Upon completion of the session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance.* Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information

For more information regarding the Family PACT Program, please call the Health Access Programs (HAP) Hotline at 1-800-257-6900 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages
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Part 2

Remove and replace:	abort 5/6
Remove:	anest 1 thru 16
Insert:	anest 1 thru 18 *(new)*
Remove and replace:	can detect 11/12 *
	cont ip 1/2 *
	hcpcs 1 thru 3 *
	inject 9 thru 12, 35/36
	inject list 17/18
	non ph 5/6, 9/10 *
	preg early 3 thru 6
	presum 17/18
	remit ex op 1/2, 5 thru 8 *
	ub comp op 11/12 *

* Pages updated/corrected due to ongoing provider manual revisions.